REQUEST FOR TRANSFER TO A DMH ADULT CONTINUING CARE INPATIENT FACILITY**

PATIENT INFORMATION

Patient's Name _____
(last) (first) (MI)

Address

_____
(number and street) (apt no) (city) (state) (zip code)

Birth Date _____ Sex _____ Race _____ Preferred Language _____
MM/DD/YY M / F Does patient speak English? ☐ Yes ☐ No

Date of Inpatient Admission: _____
MM/DD/YY

Legal Status

☐ 10 Day Hospitalization - M.G.L. c. 123, s. 12
☐ Conditional Voluntary Admission - M.G.L. c. 123, ss. 10 & 11
☐ Civil Commitment - M.G.L. c. 123, ss. 7 & 8

Guardianship

Does the patient have a court appointed legal guardian ? ☐ Yes ☐ No
(If Yes, attach copies of relevant guardianships, including Rogers Order.)

Name of legal guardian _____ Relationship _____
(last) (first) (relationship to patient)

Guardian's address

_____
(number and street) (apt no) (city) (state) (zip code)

Guardian's Telephone Number ( ) _____

Health Insurance

☐ No health coverage
☐ Medicaid/MassHealth Card #: _____ RID #:_____

MassHealth Provider ☐ HMO _____ ☐ PCC ☐ Psych Under 21 ☐ Other
(name of HMO)

☐ Medicare
☐ Other Insurance Name of Insurance: _____ Policy #:_____

Name of Policy Holder: _____

Has eligibility for DMH continuing care services already been determined for this patient? ☐ Yes ☐ No

****Note: Please use this form when applying for transfer when the patient is already a DMH client.**

Patient Name:

HOSPITAL INFORMATION

Referring Hospital:_____

Name of Treating Physician: _____ Telephone: ( )_____

Address:

_____

(number and street) (apt no) (city) (state) (zip code)

ESTIMATED LENGTH OF CONTINUED HOSPITALIZATION

Recommended Discharge Date: _____

PHYSICIAN'S STATEMENT

I have reviewed the clinical criteria for referring patients to DMH for continuing care inpatient services and believe this patient requires this level of continuing care treatment. If the patient is accepted for transfer, the transfer will comply with M.G.L. c. 123, § 3.

_____, MD

Signature of Treating Physician

Date:_____

INSTRUCTIONS:

A. Initiate a transfer request by faxing a copy of the completed form to the appropriate DMH Area Medical Director listed in Appendix C.

B. A copy of the completed form and the following attachments should then be mailed to the DMH Area Medical Director or at the Area Medical Director's discretion to the Eligibility Unit at the DMH Site Office that serves the town in which the patient lives. (See Appendix D)

1. Admission history ☐ Attached
2. Physical exam ☐ Attached
3. Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V) ☐ Attached
4. Any other initial assessments (psychosocial, medication, etc.) ☐ Attached
5. Hospital course, including treatment plan, barriers to discharge, somatic therapies and compliance, alternative therapies considered, need for Section 7, 8 and 8b, estimate of response to continued treatment, reason why any recommended treatments were not tried (if applicable) ☐ Attached
6. Last 10 days of progress notes ☐ Attached
7. Current medications ☐ Attached
8. Copies of all medication administration records (MAR) ☐ Attached
9. Copies of any relevant guardianships, including Roger's Order ☐ Attached